

## **Instructions for Authorization to Disclose Protected Health Information Form**

S.C. Ann. § 44-66-10 (Supp. 2013), known as the Adult Health Care Consent Act (AHCCA) was revised in January 2014 to require that a health care provider or the provider's agent provide on the patient information form or by electronic health records, the opportunity for the patient to designate a family member or other individual they choose as a person with whom the provider may discuss the patient's medical condition and treatment plan. This form was created to fulfill this requirement of S.C. Code Ann. § 44-66-75 (Supp. 2013).

The form must be signed by the person, guardian or surrogate. It must be completed upon the determination of DDSN eligibility and when enrolling in a new service.

The question, "DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? If YES, WHOM?" must be provided in bold print or by electronic means.

Provider will check yes or no, according to the person's wishes. When disclosure is desired, complete the name person to whom the information may be disclosed and their contact information.

Check the areas in which the person wishes information to be disclosed (medical condition, treatment plan, other). If the person wishes to disclose limited portions of those areas, detail on the form what may or may not be disclosed. For example, the person may want to disclose medical condition but not disclose prognosis.

The provider must specify that the patient may revoke or modify the authorization and that the revocation or modification must be in writing.

The revocation/modification portion of the form is to be completed if/when the person wishes to revoke authorization to disclose or change the information they wish to disclose.

This form must be maintained in the person's file.